PRINTED: 03/13/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G559		(X2) MU A. BUIL B. WINC	DING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/16/2012			
NAME OF	NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE EVERLY DR			
ARC OF	NORTHWEST IND	DIANA INC, THE		GARY,	IN 46408			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PERCEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP	E	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
W0000								
			11/00	.00				
			W00	00				
		or a fundamental						
	recertification a	nd state licensure survey.						
	Dates of survey	: February 13, 14, 15, and						
	16, 2012.							
	Provider Number	er: 15G559						
	Facility Number							
	AIM Number:	100239890						
	7 thvi i vuilloci.	100237070						
	1	Shebel, Medical Surveyor						
	III							
	The following for	ederal deficiencies also						
	reflect state find	lings in accordance with						
	460 IAC 9.							
	Quality Review	completed 2/23/12 by						
		rd, Medical Surveyor III.						
		,						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMEN	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		15G559	B. WIN			02/16/2012	
NAME OF B					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			2901 BI	EVERLY DR		
	NORTHWEST INDI	ANA INC, THE		GARY,	IN 46408		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE	DATE	
W0149	The facility must written policies a mistreatment, ner service abuse/neglect por a thorough invest of unknown origing sampled clients I (client #2).  Findings include  1. The facility's 8/1/11 to 2/13/12 2/13/12 at 1:42 Prindicated the follorigin involving Incident/Accident [Client #2], What to take [client #2], What to take [client #2 #1] noticed scratter pinky finger. Callincident/Accident herself on right preview of the 1/1 failed to indicate injury and if the investigated.  Workshop supers	incident reports, from 2, were reviewed on 2.M The review owing injury of unknown client #2: "Date of at: 1/19/2012, Name: t happened? On the way ] to bus [workshop staff ch on [client #2's] right ause of at? [Client #2] scratched binky finger." Further 9/12 incident report the cause of client #2's cause of the injury was	WO	149	Upon further review the policy and procedure for abuse and neglect is in place, per the company. However staff who originally reported to the immediate supervisor did not make management aware that was assumed that the injury occurred by scratch. Staff in ewill be retrained for further preventive measures. All staff the center will be retrained in the following areas: completing incident and accident reports; review of investigation process review of unknown screening to access unknown injuries.  To ensure future compliance residential management and diservice management will monificated all incident reports and investigations. Any uncertainties will be further reviewed.	t it  rror  at he s; tool	
	interviewed on 2	/16/12 at 11:52 A.M					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G559		A. BUILDING B. WING	00	COMPLETED 02/16/2012	
	PROVIDER OR SUPPLIER	ANA INC, THE	2901 B	ADDRESS, CITY, STATE, ZIP CODE SEVERLY DR IN 46408	
(X4) ID PREFIX TAG	(EACH DEFICIEN	ATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	workshop staff # client #2's finger "assumed she (cl herself." Worksh further stated the injury "should ha instead of assums scratched herself."  The facility's recovered on 2/16 Review of the factor Handling Cases of dated 12/20/2006 following: "III.	ords were further			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		15G559	B. WING		02/16/2012	
				ADDRESS, CITY, STATE, ZIP CODE	ı	
NAME OF F	PROVIDER OR SUPPLIEI	R		EVERLY DR		
ARC OF	NORTHWEST IND	DIANA INC, THE	GARY, IN 46408			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR		TE	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
W0154	483.420(d)(3)					
		MENT OF CLIENTS				
		t have evidence that all as are thoroughly investigated.				
	alleged violation	is are incrouginy investigated.	W0154	See tag 149 page 1	03/17/2012	
			W0134	See tag 149 page 1	03/17/2012	
		l review and interview, the				
		show evidence of a				
	thorough investi	igation of 1 of 1 injury of				
	unknown origin	which involved 1 of 2				
	sampled clients	living at the group home				
	(client #2).					
	Findings include:					
	1. The facility's	incident reports, from				
	8/1/11 to 2/13/13	2, were reviewed on				
		P.M The review				
		llowing injury of unknown				
		client #2: "Date of				
		nt: 1/19/2012, Name:				
		•				
	2	at happened? On the way				
	_	2] to bus [workshop staff				
	_	tch on [client #2's] right				
	pinky finger. Ca					
	Incident/Accide	nt? [Client #2] scratched				
	herself on right	pinky finger." Further				
	review of the 1/2	19/12 incident report				
	failed to indicate	e the cause of client #2's				
	injury and if the	cause of the injury was				
	investigated.	<del> </del>				
	in Congued.					
	Workshop super	rvisory staff #3 was				
	interviewed on 2	2/16/12 at 11:52 A.M				
	Workshop super	rvisory staff #3 stated				
		#1 did not witness how				

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	AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  15G559		00	COMP	COMPLETED 02/16/2012	
	PROVIDER OR SUPPLIER  NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2901 BEVERLY DR GARY, IN 46408				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	client #2's finger was scratched but "assumed she (client #2) scratched herself." Workshop supervisory staff #3 further stated the cause of client #2's injury "should have been investigated instead of assuming she (client #2) scratched herself." 9-3-2(a)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	
		15G559	B. WIN	G		02/16/	/2012
	PROVIDER OR SUPPLIER			2901 B	ADDRESS, CITY, STATE, ZIP CODE EVERLY DR IN 46408		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
W0159	483.430(a) QUALIFIED MEN PROFESSIONAL Each client's active integrated, considerated interview, the fact sampled clients (Service Coordinated Retardation Profescions of the fact interview Coordinated interview intervi	NTAL RETARDATION Leve treatment program must pordinated and monitored by all retardation professional. Action, record review, and cility failed for 1 of 2 octient #1) to ensure the actor (Qualified Mental dessional) incorporated unication cards into the all Program Plan at the served at the facility of on 2/13/12 from 2:45 of 2.M Workshop staff #1 derved to periodically on the #1 and assist the client of the alphabet.  #1 and #2 were not the client in utilizing cards.	wo		Service Coordinator will train DSPs at day services on using and implementing Client #1's communication can be a communication of the coordinator will mone twice monthly for three months and monthly thereafter.	irds.	03/17/2012

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	of correction identification number:  15G559	(X2) MULTIPLE CC  A. BUILDING  B. WING	00	COMPI 02/16	LETED	
	PROVIDER OR SUPPLIER  NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2901 BEVERLY DR GARY, IN 46408				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORREC'TIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
TAG	client's 12/14/11 Individual Program Plan indicated the client had communication cards which staff were to use to assist the client in indicating "happy, sad, yes, no, music, eat, drink."  Service Coordinator #1 was interviewed on 2/16/12 at 10:10 A.M Service Coordinator #1 indicated client #1's communication cards were utilized at the group home and were to be used at the workshop also. Service Coordinator #1 stated, "A set of [client #1's] communication cards was sent to the workshop and staff were trained on their usage. Staff at the workshop sometimes move from one group room to the next and probably do not always know where [client #1's] communication cards are."  9-3-3(a)	TAG	DEFICIENCY)		DATE	

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Facility ID: 001073

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	ETED
		15G559	B. WING			02/16/	2012
		<u> </u>		STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	R			EVERLY DR		
ARC OF	NORTHWEST IND	IANA INC, THE	GARY, IN 46408				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0227	specific objective client's needs, a comprehensive paragraph (c)(3)  Based on observe interview, the fas sampled clients #1's Individual Straining program #1's drooling.  Findings included Client #1 was observed workshop P.M. until 4:00 I observation periobserved to droot The chest area of saturated with sa and #2 interacted not assist the client #1's record 2/16/12 at 8:56 Arm #1's 12/14/11 Interactions with the same providing a shirt clean and dry should be seen the same providing a shirt clean and dry should be seen the same providing a shirt clean and dry should be seen the same providing as shirt clean and dry should be seen the same providing as shirt clean and dry should be seen the same providing as shirt clean and dry should be seen the same providing as shirt clean and dry should be seen the same providing as shirt clean and dry should be seen the same providing as shirt clean and dry should be seen the same providing as shirt clean and dry should be seen the same providing as shirt clean and dry should be seen the same providing as shirt clean and dry should be seen the same providing as shirt clean and dry should be seen the same providing as shirt clean and dry should be seen the same providing as shirt clean and dry should be seen the same providing as shirt clean and dry should be seen the same providing as shirt clean and dry should be same providing as shirt clean and dry should be same providing as shirt clean and dry should be same providing as shirt clean and dry should be same providing as shirt clean and dry should be same providing as shirt clean and dry should be same providing as shirt clean and dry should be same providing as shirt clean and dry should be same providing as shirt clean and dry should be same providing as shirt clean and dry should be same providing as shirt clean and dry should be same providing as shirt clean and dry should be same providing as shirt clean and dry should be same providing as shirt clean and dry should be same providing as shirt clean and dry should be	rogram plan states the es necessary to meet the is identified by the assessment required by of this section.  ration, record review, and cility failed for 1 of 2 (client #1) to ensure client Support Plan (ISP) had a in in place to address client  es:  oserved at the facility p on 2/13/12 from 2:45 P.M During the od, client #1 was ol onto her sweatshirt. If her sweatshirt was aliva. Workshop staff #1 d with client #1 but did ent in wiping her mouth, the protector, or securing a irt.  ed was reviewed on A.M Review of client dividual Program Plan er a program to address	W022	27	Client #1's team will evaluate a decide on the best method to address her drooling. Once developed staff will be trained plan.  To ensure future compliance, Service Coordinator will monitoweekly for three months and bi-weekly thereaft.	on	03/17/2012

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		IDENTIFICATION NUMBER:  15G559			COMPLETED 02/16/2012			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2901 BEVERLY DR GARY, IN 46408					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	on 2/16/12 at 10: Coordinator #1 in	ator #1 was interviewed 10 A.M Service indicated client #1 did not o address the client's						

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		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G559	B. WIN	G		02/16/	2012
NAME OF P	PROVIDER OR SUPPLIEI	3			ADDRESS, CITY, STATE, ZIP CODE EVERLY DR		
ARC OF	NORTHWEST IND	IANA INC, THE	GARY, IN 46408				
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION
TAG W0323		R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENC!)		DATE
WU323	physical examin	RVICES t provide or obtain annual ations of each client that at a es an evaluation of vision and					
	Based on record facility failed to client's (client ## within one calent Findings include Client #1's record 2/16/12 at 8:56 / indicated client was conducted of Client #2's record 2/16/12 at 9:33 / indicated client was conducted of Client #2's record 2/16/12 at 9:33 / indicated client was conducted of Client #1 was in 10:20 A.M Nuture #1 was in 10:20 A.M Nuture #1's most current conducted on 5/2	d was reviewed on A.M The review #1's last vision screening on 5/23/10. d was reviewed on A.M The review #2's last vision screening	WO	323	Client # 2 is scheduled for a vision screening on 3/30/2012 Client #1 is scheduled for a vis screening on 3/30/2012.  To ensure future compliance medical screenings will be reviewed during the annual ID assure they have been completimely.	sion T to	03/17/2012

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G559		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  02/16/2012		
	PROVIDER OR SUPPLIER			2901 BE	DDRESS, CITY, STATE, ZIP CODE EVERLY DR N 46408		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PF	ID REFIX ΓAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
W0436	repair, and teach informed choices eyeglasses, hear communications devices identified as needed by the Based on observations facility failed to requiring a wheel wheel chair which Findings include  Client #2 was obtoon 2/13/12 from P.M., at the groud 4:03 P.M. until 6 from 6:00 A.M. of the observations, wheel chair. The broken left foot of Service Coordination 2/16/12 at 10:10 Coordinator #1 in chair had been be during the past you the process of see Medicaid approving a per purchased.	furnish, maintain in good a clients to use and to make about the use of dentures, ring and other aids, braces, and other d by the interdisciplinary team e client.  ation and interview, the assure 1 of 2 clients 1 chair (client #2) had a h was in good repair.  served at the workshop 2:45 P.M. until 4:00 p home on 2/13/12 from :00 P.M., and on 2/14/12 until 7:45 A.M During client #2 was seated in a e wheel chair had a	W043	6	Due to client #2 physical spasticity, she frequently strest the left foot pedal. The Service Coordinator is monitoring the replacement of her chair week. To ensure future compliance, have secured a full wheelchair assessment. The Service Coordinator will continue to monitor the progress weekly unew chair arrives.	e ily. we	03/17/2012

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	OF CORRECTION  OF CORRECTION  15G559	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	— COM 02/	TE SURVEY MPLETED 16/2012		
	PROVIDER OR SUPPLIER  NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2901 BEVERLY DR GARY, IN 46408					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	facility's maintenance department would repair the foot rest on client #2's wheel chair until a new wheel chair was purchased. 9-3-7(a)						

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